No. 16-1140

IN THE

Supreme Court of the United States

NATIONAL INSTITUTE OF FAMILY AND LIFE ADVOCATES, D/B/A NIFLA, ET AL.,

Petitioners,

V.

XAVIER BECERRA, ATTORNEY GENERAL, ET AL.,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

BRIEF FOR SOCIAL SCIENCE RESEARCHERS AS *AMICI CURIAE* IN SUPPORT OF RESPONDENTS

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INTEREST OF *AMICI CURIAE*[1]

Amici curiae are social science, public health, and clinical researchers who have spent decades conducting and publishing research about reproductive medical services, including prenatal care, abortion, and contraception. This includes research on crisis pregnancy centers—nonprofit organizations whose mission is to persuade women to forgo abortion. *Amici* believe that the Court's resolution of this matter should be informed by valid and credible research that relates to women's reproductive healthcare. As explained in this brief, this research highlights the importance of equipping women with the information necessary to facilitate access to healthcare resources.

A full list of *amici* is attached as an appendix to this brief.

SUMMARY OF ARGUMENT

Amici respectfully submit that this Court should consider the issues presented in this case in light of certain social science and public health research that underscores the importance of equipping women with the information necessary to facilitate access to healthcare resources.

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[1] Petitioners have filed a blanket consent to the filing of amicus briefs, and Respondents have consented to the filing of this brief.

Overwhelming evidence from social science research demonstrates that the vast majority of women who decide to have an abortion are sure about their choice and want to avoid delay in obtaining care. For these women, however, crisis pregnancy centers ("CPCs")—nonprofit organizations whose mission is to persuade women to forgo abortion—may serve as a hurdle in access to care. Research shows that CPCs in many cases portray the services they provide in a potentially misleading way, and as such, we believe that there is a risk that women may visit certain CPCs based on misconceptions. Furthermore, irrespective of the reason women may visit a CPC, research has shown that many CPCs disseminate inaccurate medical information, which may risk causing harm.

We support the disclosure requirements at issue in this case, both in order to mitigate the aforementioned risks and to reduce the barriers facing women who wish to access family planning services, abortion, and prenatal care. Extensive research has documented the financial and logistical barriers that women face when accessing reproductive healthcare, including lack of insurance. The substantial cost of abortion for uninsured women is a particularly high hurdle. For states like California that have expressed a public policy interest in making abortion accessible, ensuring access to insurance for abortion patients is therefore essential. The Reproductive FACT Act effectuates this public policy interest through the requirement that all covered pregnancy-related facilities—CPCs and other covered facilities alike—disclose to patients that they may be eligible for free or

subsidized care through their county social services office.

The benefits of such a disclosure may carry over to women who want to carry their pregnancies to term as well as to women who want an abortion. Early access to prenatal care may provide important health benefits, and California has a variety of public programs designed to help women connect with and finance such care. Although most CPCs market themselves as providing healthcare services, they typically do not offer prenatal care or connect women with these public programs.

ARGUMENT

I. Research shows that crisis pregnancy centers provide inaccurate or potentially misleading information regarding abortion and contraception.

CPCs are nonprofit organizations established with the primary aim of persuading women to forgo abortion.[2] While the full number of CPCs in the United States is unknown, prior estimates, which *amici* believe are likely low, range from 2,500 to 4,000 centers across the country, compared to an estimated 1,671 abortion providers.[3] CPCs have

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[2] *See, e.g.*, Kimberly Kelly, *In the Name of the Mother: Renegotiating Conservative Women's Authority in the Crisis Pregnancy Movement*, 38:1 SIGNS: J. OF WOMEN IN CULTURE AND SOC'Y 203, 205 (2012) (ethnographic study of the CPC movement).

[3] *See* Aziza Ahmed, *Informed Decision Making and Abortion: Crisis Pregnancy Centers, Informed Consent,*

existed since the 1970s, but the sector has experienced exponential growth in recent decades.[4]

CPCs "have been widely criticized by advocacy groups and others for deceptive practices, misrepresenting their services, creating the appearance that they are comprehensive reproductive health clinics, and providing false and misleading medical information."[5] And although social science and public health research to date is limited, studies have confirmed that some CPCs (a) portray the services offered at their centers in a potentially misleading way, and (b) disseminate inaccurate information about reproductive health.

First, some CPCs market their services to pregnant women and other women of reproductive age without disclosing in advance that they do not provide abortion or contraception. A recent study of the websites of CPCs in Georgia found that, while almost all of the assessed CPC websites advertised

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and the First Amendment, 43:1 J. L., MED. & ETHICS 51, 51 (2015) (citing sources); Rachel K. Jones & Jenna Jerman, *Abortion Incidence and Service Availability in the United States, 2014*, 49:1 PERSPS. ON SEXUAL & REPROD. HEALTH 17, 22 (2017), *available at* https://www.guttmacher.org/journals/psrh/2017/01/abortion-incidence-and-service-availability-united-states-2014.

[4] Kelly, *supra* note 2, at 210, 212.

[5] Andrea Swartzendruber et al., *Sexual and Reproductive Health Services and Related Health Information on Pregnancy Resource Center Websites: A Statewide Content Analysis*, 28:1 WOMEN'S HEALTH ISSUES 14, 15 (2018).

pregnancy testing and options counseling (98% and 84%, respectively), over half of the websites—58%—lacked a notice that they did not provide or refer for abortion, and 89% lacked a notice that they did not provide or refer for contraception.[6] A study of North Carolina CPCs, which relied on phone calls and "secret shopper" visits (*i.e.*, visits by researchers posing as potential clients in order to collect data), found that 44% of the CPCs surveyed told clients that they offer counseling on abortion and its risks, while 59% disclosed that they did not provide or refer for abortions.[7]

Second, CPCs have been found to provide inaccurate and misleading medical information about abortion and contraception. For example, even though the possibility of a relationship between abortion and breast cancer has been thoroughly debunked,[8] 16% of the CPCs visited in the North Carolina study warned women of a link between abortion and breast cancer, and 11% made such claims on their websites.[9] Similarly, the study of Georgia CPC websites found that 8% of websites reviewed linked abortion to

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[6] *Id.* at 16.

[7] Amy G. Bryant & Erika E. Levi, *Abortion Misinformation from Crisis Pregnancy Centers in North Carolina*, 86 CONTRACEPTION 752, 753 (2012).

[8] *See* Swartzendruber, *supra* note 5, at 16 (citing sources); Bryant & Levi, *supra* note 7, at 754 (same); Joanne D. Rosen, *The Public Health Risks of Crisis Pregnancy Centers*, 44:3 PERSPS. ON SEXUAL & REPROD. HEALTH 201, 201 (2012) (same).

[9] Bryant & Levi, *supra* note 7, at 753.

breast cancer.[10] Such CPCs persist in making these claims in the face of overwhelming evidence to the contrary: in 2003, more than 100 of the world's leading experts who study pregnancy and breast cancer risk "concluded that having an abortion or miscarriage does not increase a woman's subsequent risk of developing breast cancer."[11]

The inaccurate information provided by CPCs does not stop at unfounded claims about breast cancer. The North Carolina study also found that counselors at 21% of CPCs visited warned women of a phony link between abortion and infertility.[12] In fact, medical evidence has clearly disproved the alleged link.[13]

CPCs often warn of adverse mental health consequences of abortion, such as "post-abortion syndrome." According to the North Carolina study, 26% of the CPCs visited claimed a link between abortion and mental health risks and 31% made such claims on their websites.[14] The study of Georgia CPC websites found that 36% of the websites reviewed claimed that abortion leads to mental health problems.[15] In point of fact, "post-abortion syndrome" is not supported by credible medical

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[10] Swartzendruber, *supra* note 5, at 16.

[11] Abortion, Miscarriage, and Breast Cancer Risk: 2003 Workshop, Nat'l Cancer Inst., https://www.cancer.gov/types/breast/abortion-miscarriage-risk.

[12] Bryant & Levi, *supra* note 7, at 753-54.

[13] *See id.* at 754 (citing sources).

[14] *Id.* at 753-54.

[15] Swartzendruber, *supra* note 5, at 16.

research, nor recognized by the American Psychological Association or the American Psychiatric Association.[16] Indeed, according to the American Psychological Association's Task Force on Mental Health and Abortion, "[t]he best scientific evidence published indicates that among adult women who have an unplanned pregnancy the relative risks of mental health problems is no greater if they have a single first-trimester abortion than if they deliver that pregnancy."[17] And a causal link between multiple abortions and mental health harms has not been established.[18]

Beyond abortion, CPCs have also been found to provide incorrect medical information about contraception, often inaccurately downplaying its efficacy. For example, 78% of CPC websites surveyed in Georgia that contained information about condoms included "statements that seemed to be designed to undermine confidence in condom effectiveness or false statements about condom effectiveness."[19] Of the CPCs visited in North

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[16] *See* Bryant & Levi, *supra* note 7, at 754; Rosen, *supra* note 8, at 202.

[17] APA TASK FORCE ON MENTAL HEALTH AND ABORTION, REPORT OF THE APA TASK FORCE ON MENTAL AND ABORTION 4 (2008), *available at* http://www.apa.org/pi/wpo/mental-health-abortion-report.pdf.

[18] Swartzendruber, *supra* note 5, at 19.

[19] *Id.* at 17

Carolina, 26% conveyed that condoms are ineffective.[20]

Although research on how women respond to potentially misleading portrayals of services offered or inaccurate medical information is still developing, two recent studies suggest that some women may misunderstand the services offered by CPCs. In a recent study of women at Nebraska abortion clinics, 15% of women surveyed reported that they had previously contacted a CPC, while 12% reported that they had only contacted a CPC before presenting at the abortion clinic.[21] Furthermore, these women mentioned CPC staff when asked to identify persons "providing healthcare and with whom [they] discussed the pregnancy," underscoring the need for clear and accurate information about CPCs' intentions and services.[22] In addition, a recent qualitative study into the barriers to abortion care that drive women to travel long distances for an abortion found that four out of 29 women pointed to encounters with CPCs as having impeded their access to care.[23]

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[20] Bryant & Levi, *supra* note 7, at 753. *See also* Katelyn Bryant-Comstock et al., *Information about Sexual Health on Crisis Pregnancy Center Web Sites: Accurate for Adolescents?*, 29 J. OF PEDIATRIC & ADOLESCENT GYNECOLOGY 22, 23-24 (2016).

[21] Valerie French et al., *Influence of Clinician Referral on Nebraska Women's Decision-to-Abortion Time*, 93 CONTRACEPTION 236, 238-39 (2016).

[22] *Id.* at 241.

[23] *See* Jenna Jerman et al., *Barriers to Abortion Care and Their Consequences for Patients Traveling for Services:*

More broadly, research suggests that women want to know what treatment is available at a facility before they seek care there. Specifically, one survey found that more than 80% of women found it somewhat or very important to know about a hospital's religiously motivated restrictions on care.[24] Research also shows that women expect to receive the full range of reproductive health services whether or not the facility where they seek health care has a religious affiliation.[25]

Based on the research that has been conducted to date, *amici* believe there is a risk that some women may visit certain CPCs with a misconception about which services are provided and which are not, and while there, may receive scientifically and medically inaccurate information. Such findings indicate that patient interests are served by disclosures about limitations on care, and information that may connect them with the care they seek.

Qualitative Findings from Two States, 49:2 PERSPS. ON SEXUAL & REPROD. HEALTH 95, 98 tbl. 2 (2017).

[24] *See* Lori R. Freedman et al., *Religious Hospital Policies on Reproductive Care: What Do Patients Want to Know?*, 218:2 AM. J. OF OBSTETRICS & GYNECOLOGY 251 (2018).

[25] *See* Maryam Guiahi et al., *Are Women Aware of Religious Restrictions on Reproductive Health at Catholic Hospitals? A Survey of Women's Expectations and Preferences for Family Planning Care*, 90 CONTRACEPTION 429 (2014).

II. Research demonstrates that the vast majority of women who decide to have an abortion are sure about their decision, and want to avoid delay in obtaining care.

CPCs claim that their goal is to present "abortion-minded" or "abortion-determined" women with information and counseling intended to change their minds about their pregnancy decision. They claim that drawing women into CPCs will have a beneficial effect on their decision-making by promoting alternatives to abortion. In addition, they claim that by dissuading women from choosing abortion, they will prevent abortion-related regret.[26]

Contrary to this premise, research shows that women who present for an abortion are confident in their decision.[27] Indeed, the research demonstrates

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[26] *See, e.g.*, Impacted by Abortion, Care-Net, https://www.care-net.org/impacted-by-abortion (providing resources to cope with "post-abortion pain" and promote "post-abortion recovery"); Susie Meister, *How my job talking women out of abortions made me pro-choice*, Vox (May 26, 2016), https://www.vox.com/2016/5/26/11760670/crisis-pregnancy-center (describing the practices of a particular CPC, including that the author was "directed to tell women that studies show they will regret an abortion for the rest of their lives").

[27] Lauren J. Ralph et al., *Measuring Decisional Certainty Among Women Seeking Abortion*, 95:3 CONTRACEPTION 269 (2017) (based on a survey of over 300 women in Utah family planning facilities, finding that the level of uncertainty in abortion decision making is comparable to or lower than other health decisions); Mary Gatter et al., *Relationship Between Ultrasound Viewing and Proceeding to Abortion*, 123:1 OBSTETRICS &

that women deciding whether to have an abortion are less conflicted than those making other common healthcare decisions.[28] And, once the decision is made, they are unlikely to change their minds. One study found that, among women in Utah who were confident in their decision to have an abortion, 95% were no less certain after they surpassed the state's mandatory three-day waiting period.[29]

Research also demonstrates that women who have decided to have an abortion want to do so without delay. For example, 94% of medication abortion patients said it was very important to them to have an abortion early in pregnancy.[30] In fact, most abortion patients, including 52% of those obtaining abortions in the first trimester, said they would have preferred to have had an abortion earlier, but

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GYNECOLOGY 81 (2014) (based on a sample of over 15,000 women, finding that 85% of the women presenting at California abortion clinics were confident and clear about the decision to have an abortion, and among these, viewing an ultrasound image of the fetus had no effect on the ultimate decision to have an abortion).

[28] Ralph, *supra* note 27, at 276 (finding that women were less conflicted about the decision to have an abortion than were all genders regarding reconstructive knee surgery, as well as compared to men deciding on prostate cancer treatment options).

[29] Sarah C.M. Roberts et al, *Do 72-hour Waiting Periods and Two-Visits Requirements for Abortion Affect Women's Certainty? A Prospective Cohort Study*, 27:4 WOMEN'S HEALTH ISSUES 400 (2017).

[30] Daniel Grossman et al., *Effectiveness and Acceptability of Medical Abortion Provided Through Telemedicine*, 118:2 OBSTETRICS AND GYNECOLOGY 296 (2011).

financial limitations (or lack of knowledge about pregnancy) caused delay.[31]

Furthermore, women who have had an abortion overwhelmingly continue to believe they made the right decision after the abortion.[32] In one study of post-abortion emotions that women experience, more than 95% of women reported that the abortion was the right decision at all points over the three years following the abortion, and the feeling of decisional rightness tended to increase over time.[33]

Neither does abortion have a negative effect on women's mental health. Recent studies and systematic reviews of the literature have found that, contrary to claims made by abortion opponents, abortion does not cause depression, suicidal ideation, anxiety, or other mental health harms.[34]

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[31] Lawrence B. Finer et al., *Timing of Steps and Reasons for Delays in Obtaining Abortions in the United States*, 74:4 CONTRACEPTION 334 (2006).

[32] Corinne H. Rocca et al., *Decisional Rightness and Emotional Responses to Abortion in the United States: A Longitudinal Study*, 10:7 PLOS ONE (2015), *available at* http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0128832.

[33] *Id.* at 7.

[34] See, e.g., Vignetta E. Charles et al., *Abortion and Long-Term Mental Health Outcomes: A Systematic Review of the Evidence*, 78:6 CONTRACEPTION 436, 439–448 (2008); Susan A. Cohen, *Still True: Abortion Does Not Increase Women's Risk of Mental Health Problems*, 16:2 GUTTMACHER POL'Y REV. 13, 13–14 (2013).

III. Research shows that women face financial and logistical burdens when accessing abortion, and lack of access to insurance may contribute to delays.

For women paying out of pocket, abortion is expensive, with the median cost ranging from $490 to $1,750, depending on the timing of the procedure.[35] Such costs would consume 24% to 85% of the monthly income of a family of four living at the federal poverty line—a level that exceeds the monthly income of nearly half of abortion patients. For states like California that have expressed a public policy interest in making abortion accessible, ensuring access to insurance for abortion patients is therefore essential. The notice required of all licensed covered facilities under the FACT Act (the "signage requirement")—which provides information about how to access public programs that provide "free or low-cost access to comprehensive family planning services, (including all FDA-approved methods of contraception), prenatal care, and abortion for eligible women"—effectuates this important state policy.[36]

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[35] Sarah C.M. Roberts et al., *Out-of-Pocket Costs and Insurance Coverage for Abortion in the United States*, 24:2 WOMEN'S HEALTH ISSUES e211, e214 (2014). Other studies have found similar cost increases over time. *See, e.g.*, Ushma D. Upadhyay et al., *Denial of Abortion Because of Provider Gestational Age Limits in the United States*, 104:9 AM. J. OF PUB. HEALTH 1687 (2014).

[36] CAL. HEALTH & SAFETY CODE § 123472(a)(1).

A. Lack of financial resources delays access to abortion.

For women who cannot use insurance to pay for their abortions, the need to pay out of pocket is a significant barrier, leading some woman to forgo payment of other bills.[37] For more than half of women paying for an abortion out-of-pocket, these costs were equivalent to more than one-third of monthly personal income, and this was closer to two thirds among those receiving later abortions.[38] Lack of financial resources is associated with longer delays in obtaining an abortion, which may result in a woman being unable to obtain an abortion at all due to exceeding the gestational limit for her state or care provider.[39] Indeed, among women denied an abortion because their pregnancies had advanced beyond the provider's gestational limit, the need to raise funds to pay for the procedure was the most commonly reported reason for delay.[40]

Such hardships are especially challenging because the most common reasons that women seek abortions are financial.[41] As referenced above, nearly half of abortion patients live below the federal poverty level

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[37] Rachel K. Jones et al., *At What Cost? Payment for Abortion Care by U.S. Women*, 23:3 WOMEN'S HEALTH ISSUES e173 (2013).

[38] Roberts et al., *supra* note 35, at e214.

[39] Upadhyay et al., *supra* note 35, at 1689.

[40] *Id.*

[41] M. Antonia Biggs et al., *Understanding Why Women Seek Abortions in the United States*, 13:29 BMC WOMEN'S HEALTH 1, 5-6 (2013).

(*i.e.*, $24,600 annual income for a family of four), and three in four live below 200% of the poverty line.[42] In such circumstances, missing one day of work—much less two—means losing wages that an individual or family can ill-afford to forgo.

When women face delays in obtaining an abortion, the logistical and financial burdens they face multiply. On average, a woman must wait at least a week between when she attempts to make an appointment and when she receives an abortion.[43] Additionally, in many cases, personal circumstances—such as the need to arrange for childcare or transportation, or to raise money to pay for the procedure—may cause additional delays.[44]

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[42] JENNA JERMAN ET AL., CHARACTERISTICS OF U.S. ABORTION PATIENTS IN 2014 AND CHANGES SINCE 2008, 7 (2016), *available at* https://www.guttmacher.org/sites/default/files/report_pdf/characteristics-us-abortion-patients-2014.pdf.

[43] The median is seven days, while the average is 10 days. Moreover, poorer women wait two to three days longer than the typical woman. *See* Finer et al., *supra* note 31, at 338, 343.

[44] *See* Liza Fuentes et al., *Women's Experiences Seeking Abortion Care Shortly After the Closure of Clinics Due to a Restrictive Law in Texas*, 93:4 CONTRACEPTION 292 (2016) (finding, in the context of the HB2-related clinic closures, that women who had to arrange transportation or could not take time off of work on the day of the next available appointment were delayed even further); *see also* Sarah C.M. Roberts et al., *Utah's 72-Hour Waiting Period for Abortion: Experiences Among a Clinic-Based Sample of Women*, 48:4 PERSPS. ON SEXUAL & REPROD. HEALTH 179, 185 (2016) (finding that having to raise additional funds was a reason for waiting longer than the required 72-hours).

Delays also have the effect of increasing the cost of an abortion. Abortion in the first trimester is substantially less expensive than in the second trimester: the median price of a surgical abortion at 10 weeks is $508, while the cost rises to $1,195 at week 20.[45] Another study found that abortion (up to 14 weeks) is $490, compared to $750 for weeks 14 to 20, and $1,750 after week 20.[46] The rising cost of abortion as gestational age increases poses a profound challenge to the affordability of the procedure for lower-income women. As one Utah woman explained: "I knew the longer it took, the more money it would cost . . . . We are living paycheck to paycheck as it is, and if I [had] gone one week sooner, it would have been $100 less."[47]

Moreover, delays raise the cost of each step of obtaining an abortion—not just the cost of the procedure. For example, one recent study found that Utah's mandatory waiting period caused 47% of women having an abortion to miss an extra day of work.[48] More than 60% were negatively affected in

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[45] Rachel K. Jones et al., *Differences in Abortion Service Delivery in Hostile, Middle-Ground and Supportive States in 2014*, WOMEN'S HEALTH ISSUES (forthcoming 2018), *available at* http://www.whijournal.com/article/S1049-3867(17)30536-4/pdf.

[46] Roberts et al., *supra* note 35. Other studies have found similar increases over time. *See, e.g.*, Upadhyay et al., *supra* note 35 at 1687.

[47] Roberts et al., *supra* note 44, at 184.

[48] Jessica N. Sanders et al., *The Longest Wait: Examining the Impact of Utah's 72-Hour Waiting Period for Abortion*, 26:5 WOMEN'S HEALTH ISSUES 483, 485 (2016).

other ways, including increased transportation costs, lost wages by a family member or friend, or being required to disclose the abortion to someone whom they otherwise would not have told.[49] And because many clinics do not offer second-trimester abortions, a woman who has been delayed into the second trimester will typically be required to travel farther to obtain an abortion, thereby incurring additional travel and related costs, such as lost wages.[50]

As discussed above, sometimes women are delayed past the point in time at which a state or clinic no longer permits abortion. Denial of abortion services due to exceeding gestational limits has serious consequences. When women are denied wanted abortions, they are less likely to be employed, and more likely to fall below the poverty level—even though they are more likely to receive increased levels of public assistance.[51] They are also less likely to achieve aspirational plans for the coming year.[52]

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[49] *Id.*; *accord* Deborah Karasek et al., *Abortion Patients' Experience and Perceptions of Waiting Periods: Survey Evidence Before Arizona's Two-Visit 24-hour Mandatory Waiting Period Law*, 26:1 WOMEN'S HEALTH ISSUES 60 (2016).

[50] Rachel K. Jones & Jenna Jerman, *How Far Did US Women Travel for Abortion Services in 2008?*, 22:8 J. OF WOMEN'S HEALTH 706 (2013).

[51] Diana Greene Foster et al., *Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions in the United States*, 108:3 AM. J. OF PUB. HEALTH 407 (2018).

[52] Ushma D. Upadhyay et al., *The Effect of Abortion on Having and Achieving Aspirational One-Year Plans*, 15:102 BMC WOMEN'S HEALTH 1 (2015).

And they are more likely to remain in relationships with partners who subject them to physical violence.[53]

B. Women Face Difficulties in Obtaining and Using Insurance Coverage for Abortion.

Research shows that women seeking abortion face hurdles in obtaining insurance coverage, even when public programs are available. In Massachusetts, where public insurance covers abortion, some women still paid out of pocket for abortion because they were uninsured. Most commonly, uninsured women reported that they either (a) had applied for insurance but not yet been approved; (b) faced challenges in navigating the enrollment process; or (c) had difficulty recertifying eligibility.[54] Also in Massachusetts, women who had been referred to subsidized insurance programs at the time they were seeking abortion widely reported that the application process was confusing—with younger women reporting the highest levels of confusion with the process.[55]

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[53] Sarah C.M. Roberts et al., *Risk of Violence from the Man Involved in the Pregnancy after Receiving or Being Denied an Abortion*, 12:144 BMC MEDICINE 1 (2014).

[54] Amanda Dennis et al., *A Qualitative Exploration of Low-Income Women's Experiences Accessing Abortion in Massachusetts*, 25:5 WOMEN'S HEALTH ISSUES 463 (2015).

[55] Danielle Bessett et al., *Out of Time and Out of Pocket: Experiences of Women Seeking State-Subsidized Insurance for Abortion Care in Massachusetts*, 21:S3 WOMEN'S HEALTH ISSUES S21 (2011).

Lack of insurance, or problems with insurance, may lead to delay. In a study comparing women who received an abortion with those who were denied an abortion because of gestational limits, women commonly cited "insurance problems" as a factor delaying their abortions, including administrative and logistical problems like having to determine whether the procedure was covered among women with insurance, or waiting for Medicaid-based coverage where available.[56] In a study focused on California women, women who had second trimester abortions were more likely to report trouble with insurance coverage as a factor causing delay than first trimester patients.[57] More generally, in states where public insurance includes coverage for abortion, residents are less likely to report cost as a reason for delay.[58]

Given these difficulties, delays related to insurance coverage, and burdens exacerbated by delays, California has a compelling interest in informing women that public programs exist, and how they can access them.

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[56] Upadhyay et al., *supra* note 35, at 1689, 1691.

[57] Eleanor A. Drey et al., Risk Factors Associated with Presenting for Abortion in the Second Trimester, 107:1 OBSTETRICS & GYNECOLOGY 128 (2006). One confounding factor noted by the authors is that second trimester patients may also have been more likely to need insurance, because the cost of the procedure rises with gestational age. Id.

[58] Sarah C.M. Roberts et al., *Out-of-Pocket Costs and Insurance Coverage for Abortion in the United States*, 24:2 WOMEN'S HEALTH ISSUES e211 (2014)

IV. Research demonstrates the importance of early entry into prenatal care, but CPCs in California do not assist women in accessing prenatal care.

Of course, some women who visit CPCs do not want abortions, but rather seek assistance with respect to pregnancies they plan to carry to term.[59] These women go to CPCs to obtain pregnancy tests, ultrasounds, and other services. Studies to date indicate that CPCs typically do not provide onsite prenatal care.[60]

Early entry into prenatal care can facilitate behaviors that are important for birth, infant, and child outcomes. For example, early enrollment in prenatal care may identify and treat key health issues, prevent harms to the fetus from ongoing use of medications that are not safe during pregnancy, and provide links to key services and supports that have been shown to improve birth outcomes.[61]

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[59] *See* Kimberly Kelly, *Evangelical Underdogs: Intrinsic Success, Organizational Solidarity, and Marginalized Identities as Religious Movement Resources*, 43:4 J. OF CONTEMP. ETHNOGRAPHY 419, 423 (2014); Katrina Kimport et al., *The Prevalence and Impacts of Crisis Pregnancy Center Visits among a Population of Pregnant Women*, CONTRACEPTION (forthcoming Mar. 2018), *abstract available at* http://www.contraceptionjournal.org/article/S0010-7824(17)30262-7/fulltext.

[60] Kimport et al., *supra* note 59.

[61] *See* What is prenatal care and why is it important, Eunice Kennedy Shriver Nat'l Inst. of Child Health and Human Dev., https://www.nichd.nih.gov/health/topics/pregnancy/conditioninfo/prenatal-care (observing that prenatal care can help ensure the medications women

Although prenatal care confers these benefits, women may not know that they are eligible for pregnancy-specific coverage, and bureaucratic hurdles to enrolling can be a deterrent.[62] Among the measures found to facilitate earlier entry into prenatal care is "presumptive eligibility." "Presumptive eligibility" means that states may allow certain providers (such as local health departments, community health centers, and hospitals) to determine temporary eligibility for Medicaid, and to provide prenatal care while the

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take are safe); *see also* Nancy E. Reichman et al., 8:2 REV. ECON. HOUSEH. 171 (June 2010) (finding that first-trimester prenatal care appears to decrease maternal postpartum smoking by approximately five percent); Ralitza Gueorguieva et al., *Length of Prenatal Participation in WIC and Risk of Delivering a Small for Gestational Age Infant: Florida, 1996-2004*, 13:4 MATERNAL & CHILD HEALTH J. 479 (July 2009) (finding that enrollment in WIC and Medicaid-funded prenatal services was associated with reduced incidence of low birth weight); Nancy E. Reichman & Julian O. Teitler, *Timing of Enhanced Prenatal Care and Birth Outcomes in New Jersey's HealthStart Program*, 9:2 MATERNAL & CHILD HEALTH J. 151 (June 2005) (finding that initiating prenatal care in the first or second trimester was associated with a 1-day advantage in gestational age); Victoria Lazariu-Bauer et al., *A Comparative Analysis of Effects of Early Versus Late Prenatal WIC Participation on Birth Weight: NYS, 1995*, 8:2 MATERNAL & CHILD HEALTH J. 77 (June 2004) (finding that infants born to WIC participants who enrolled in prenatal care early were heavier than those who enrolled late).

[62] Sarah C.M. Roberts &, Cheri Pies, *Complex Calculations: How Drug Use During Pregnancy Becomes a Barrier to Prenatal Care*, 15 MATERNAL & CHILD HEALTH J. 333 (2011).

application is being processed.[63] As a consequence, patients can enroll in coverage and obtain care on the spot, instead of having to wait for coverage, and make additional visits to a health care facility when coverage is approved.[64] Presumptive eligibility has been shown to lead to increased use of prenatal care, and certain beneficial outcomes, such as smoking cessation.[65]

Based on publicly accessible information provided by California's Department of Health Care Services, CPCs generally do not enroll women who want to continue their pregnancies into presumptive eligibility insurance so that they can receive subsidized prenatal care.[66] The FACT Act's signage

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[63] Joyce M. Piper, *Presumptive Eligibility For Pregnant Medicaid Enrollees: Its Effects on Prenatal Care and Perinatal Outcome*, 84:10 AM. J. PUB. HEALTH 1626 (1994).

[64] *Id.*

[65] Marian Jarlenski et al., *Medicaid Enrollment Policy Increased Smoking Cessation Among Pregnant Women But Had No Impact On Birth Outcomes*, 33:6 HEALTH AFFS. 997 (2014).

[66] This conclusion was derived by cross-referencing a directory of pregnancy service providers provided by *amicus curiae* HeartBeat International ("HeartBeat") with California's list of providers that are eligible to enroll women in presumptive eligibility. HeartBeat is a 501(c)(3) organization that "serves approximately 2,400 pro-life centers, maternity homes, and non-profit adoption agencies in over 50 countries—making Heartbeat the world's largest such affiliate network." *Amicus Curiae* Brief of HeartBeat International at 1. Among other services, HeartBeat provides a "Worldwide Directory of Pregnancy Help," which lists 357 service providers in

requirement thus makes use of an opportunity to connect women with coverage at the time and place that they are seeking pregnancy-related services—an opportunity that might otherwise be missed. Indeed, neither petitioners nor their *amici* have identified whether CPCs use any other means to inform women how to obtain insurance coverage for pregnancies that they plan to continue.

CONCLUSION

We respectfully request the Court consider the issues presented in this case in light of the social science and public health research discussed above.

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Respectfully submitted,

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California alone, of which 71 are HeartBeat affiliates. Only 4.2% of service providers listed, and 8.4% of HeartBeat affiliates are eligible to enroll women into presumptive eligibility insurance so that they can receive subsidized prenatal care. *Compare* Worldwide Directory of Pregnancy Help, HeartBeat International, https://www.heartbeatinternational.org/worldwide-directory (filtered for California as of Feb. 25, 2018), *with* Find a Qualified Provider to Enroll, California Department of Health Services, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/Find-a-Qualified-Provider-to-Enroll.aspx (as of Feb. 25, 2018).

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